

CHAPTER 7

MANAGED MENTAL HEALTH CARE

BACKGROUND

Over the last few years, the orientation of health care has changed from the delivery of episodic treatment of illness to the planned provision of primary care and other necessary services in an integrated, coordinated system of service delivery. This coordinated system of care is known as managed care. Managed care, broadly stated, is a planned, comprehensive approach to providing health care that combines clinical services and administrative procedures within an integrated, coordinated system. This system is carefully constructed to provide timely access to care and services in a cost-effective manner. In a managed care system, individual providers are linked together under the umbrella of a single entity: the managed care plan. Managed care's emphasis on access to health care is intended to increase the utilization of primary care services whenever possible and thus reduce the unnecessary use of emergency rooms and inpatient services. Similarly, managed care's focus on mental health preventive services concentrates on promotion of a person's ability to function in the community (California Department of Mental Health, 1997, page 18).

History of Mental Health Funding in California: the Short-Doyle Program

In 1957, state legislation created the Short-Doyle program, which established a county-based delivery system for mental health services. Initially, the program was voluntary, and each county was encouraged to start local community-based services. However, some counties did not take advantage of this opportunity to develop local services. To provide added incentive, the State implemented a matching formula and developed a 50-50 funding split, in which the State matched each county dollar expended. County participation was still slow in developing, so the State changed the formula to 75 percent from the State and 25 percent from the counties. The formula was changed once more to 90 percent state funds and 10 percent county funds, except for inpatient services, which were funded 85 percent state funds and 15 percent county funds in order to encourage counties to use less costly

outpatient services. Eventually, the State required all counties to ensure delivery of mental health services.

Medi-Cal

In 1966, California enacted the Medicaid program, referred to as "Medi-Cal." This program allowed the State to receive federal financial participation to provide health care services, including mental health services, to eligible residents who were federal cash grant welfare recipients. These services, also known as Fee-for-Service Medi-Cal (FFS/MC), were provided by a voluntary network of private providers throughout the State. For mental health services, those providers would be psychiatrists and psychologists. The rates for FFS/MC have been significantly less than providers' usual and customary rates.

Short-Doyle Medi-Cal

In 1971, the Short-Doyle/Medi-Cal (SD/MC) program was established. It allowed counties to obtain a 50 percent federal match on their costs for providing certain mental health services to persons eligible for Medi-Cal. At this point, the Medi-Cal program split into two mental health service delivery systems: the existing FFS/MC program continued mainly as a system of private providers, and the SD/MC program was established as a system of public providers, primarily county mental health programs and their contracted community agencies. As previously noted, the FFS/MC system was primarily solo practitioners in psychiatry and psychology, whereas in the SD/MC program the services were provided in a clinic setting. Psychologists, social workers, marriage and family counselors, and other ancillary therapists who were under the auspices of a medical director of a clinic were able to provide a range of services to clients. The reason for establishing the SD/MC program was to allow for a wider variety of treatment options to adults with mental illness and children and youth with serious emotional disturbances than the office-based private practitioner of the FFS system was able to provide.

Equity of Mental Health Funding at the County Level

During the development of the State's Short-Doyle program in the late 1960s, some counties were aggressive in matching dollars and others were not. As a result, historical inequities in funding developed. These inequities were compounded when many counties also did not pursue the 50 percent federal match for Short-Doyle/Medi-Cal. As a result, those counties had far less resources for providing mental health services to the clients in their communities. These inequities continue to the present day because the funding formula for realignment reflects the original matching formulas and each county's individual level of participation prior to the enactment of realignment.

Although the need to achieve equity in funding among California counties has been an issue of contention, no under-equity county has ever been able to catch up. These historical and persistent inequities affect the level of Medi-Cal funds per capita available for each California county as well. Some counties have very little Medi-Cal funding, and others have a great deal. The result is a patchwork quilt of uneven levels of funding and uneven access to services throughout the State. Prior to realignment, a plan to reallocate these dollars, either Short-Doyle or Medi-Cal, was never attempted because of the political ramifications of taking from one county to give to another.

California's "Managed" Mental Health Program

California has had to "manage" the provision of public mental health services for many years due to limited resources and defined target populations. The bulk of funding for public mental health services, which came from the State General Fund, was discretionary. Goodwin and Selix describe the decline in mental health funding:

The current level of funding to mental health is estimated to be less than half that which is needed to provide a basic level of care for the existing mentally ill population. Beginning with an inadequate funding base, state allocations to counties were severely diminished due to inflation throughout the 1970s and 1980s, inadequate cost

of living increases, and increasing population with increasingly serious problems. From 1982 to 1987, there were no cost-of-living increases or caseload adjustments to community mental health. In 1988, funds were reduced, and in 1989, an additional fifteen percent was reduced from the base funding for community mental health.

In 1990, California faced a \$14.3 billion shortfall. Community mental health programs were already near collapse and overwhelmed with unmet need. Advocates feared massive budget cuts to programs that could be irreparable. Significant policy and fiscal decisions regarding the future of community mental health programs had to be made quickly (Goodwin & Selix, 1998).

In 1991, in an effort to stop the continued assault on mental health funding, California enacted a law (Chapter 89, Statutes of 1991) providing that a portion of the sales tax and revenues collected from vehicle licensing fees would be used to establish a Local Revenue Fund. This fund is restricted to expenditures for county health, mental health, and social services. This realignment of funding from the State to the counties saved the mental health system from financial disaster by removing funding for mental health services from the discretionary State General Fund. Counties now could rely on a constant funding base from which to plan for the provision of mental health services. In addition, this law also established target populations for adults, children and youth, and older adults that specified the diagnoses and functional limitations necessary for a client to meet the target population definition, ensuring that those clients with the most severe mental illnesses received services.

In the early 2000s, several county mental health programs have begun to experience shortfalls in realignment findings and are relying on a variety of methods to make up the difference. If counties are unable to fund their mental health programs adequately, they may be forced to return responsibility and control of the programs to the State. Because of the many policy and fiscal changes that have taken place over the last 10 years, Chapter 367, Statutes of 2001 (AB 328, Salinas) was enacted, which requires that the DMH, in cooperation

with the CMHDA and other relevant parties, reexamine realignment.

7.1. Recommendation: The State of California must increase base funding overall for mental health programs.

The Move to Medi-Cal Mental Health Managed Care in California -- the "Carve-Out"

In step with the national trend, the Department of Health Services (DHS), which is the single state agency overseeing Medi-Cal, made a commitment to refocus the delivery of healthcare from episodic treatment for illness to the planned provision of services in a managed care model of service delivery. Following the policies of DHS, the Department of Mental Health (DMH) implemented a managed mental health care system for Medi-Cal services.

The DMH decided to "carve out" mental health care from the physical health care system into an individual managed care plan. In other words, public mental health services funded by Medi-Cal are separate from the physical health services managed care system. The DMH believes that carving out mental health care ensures that mental health services will be provided more appropriately and more effectively.

The Design of California's Managed Mental Health Medi-Cal Program

The design of managed mental health care for California's Medi-Cal program is based on statewide implementation of a single managed mental health plan (MHP) in each county. The implementation of managed care with the county as the mental health plan is the logical extension of the state and county relationship. The counties are the primary sources of service to persons with mental illness and emotional disturbance and have the ability to provide culturally and linguistically competent continuity of care for those periods when persons are not eligible for Medi-Cal but still require "safety net" services to maintain themselves in the community. Additionally, the counties are responsible for the provision of many high-cost public services used by persons with mental illness, such as foster care, juvenile justice, indigent health care, and jail services.

The DMH operates under a "Freedom of Choice" waiver, under Section 1915(b) of the federal Social Security Act. This waiver, which is reviewed and approved by the Center for Medicare and Medicaid Services, allows California to limit a Medi-Cal beneficiary's choice of providers for mental health services as long as access and quality of services are ensured. This waiver is subject to review and must be renewed every two years. The most recent waiver was effective through November 2002. The DMH has applied for another renewal of this waiver and will know in early 2003 if it is granted.

Consolidation versus Capitation

California's mental health managed care system is not a capitated system in which MHPs would be paid a fixed amount for each beneficiary regardless of the amount or cost of services received by the beneficiary. Capitation would require the State to spread the full risk for provision of services to the MHPs. Spreading the risk evenly is problematic because of the great inequity in the historical base of allocation for both realignment funds and Medi-Cal dollars in the State. For this reason, the counties and State have begun to examine other ways to share risk that would still assure that the beneficiaries receive access to services and that providers, whether county-operated or contracted, do not go into bankruptcy.

California's Phase-In Approach to Implementation

California chose to phase in implementation in order to assure an orderly process. Implementation included two phases with the final phase of a pre-payment system to be implemented in the future when access and full risk management to the MHPs can be assured on a statewide basis.

Phase I: Consolidation of Psychiatric Inpatient Hospital Services

Consolidation under Phase I began in January 1995. Funds previously appropriated for DHS to pay for FFS/MC inpatient hospital mental health services were transferred to the MHPs, making the MHPs the single point of authorization and payment of Medi-Cal psychiatric inpatient hospital services. MHPs negotiate contract requirements and rates with inpatient hospital providers using state and

federal law and regulations as minimum requirements.

Phase II: Consolidation of Specialty Mental Health Services

In addition to assuming the risk for inpatient hospital services, MHPs are assuming the risk and funding for Medi-Cal specialty mental health services, which include outpatient and service coordination. Consolidation of hospital and outpatient services results in one system of care with a single fixed point of responsibility and accountability, thereby maximizing the chances for beneficiaries to receive appropriate care.

Phase III: Implementation of a Pre-payment System

The DMH will continue to explore the implementation of capitation. It believes that the development of a pre-payment system must be based on extensive analysis of data of a particular population to be served. This in-depth financial analysis is crucial to achieve reliable information on costs for risk-based contracting. For this reason, the counties and State have begun to look at other ways to share risk and to assure that beneficiaries receive access to services, as well as assure that county-operated and contracted providers remain financially viable. Types of alternative contracting include the following:

- ◆ **Case Rate Contract.** Under this model, contracted services are based on a type of group or population.
- ◆ **Partial Capitation.** Under this model, contracted services are based on the number of recipients expected to use a certain type of service.
- ◆ **Capitation with Risk Corridor.** This model incorporates a set-aside for costs exceeding the normal amount of risk. For example, a risk pool may be established in which a percentage of each premium goes into a fund, a provider may buy insurance to protect against catastrophic losses, or several counties might form a risk pool together.

CMHPC'S PRIORITIES

The California Mental Health Planning Council (CMHPC) chose its priorities for managed care

by focusing on issues that would remain salient, as well as issues that other constituency groups were not already closely examining.

Meaningful involvement of clients and family members

The DMH has made a commitment to ensure that consumer and family involvement is an overriding value in planning, implementation, and oversight. Most significantly, the DMH established the Client and Family Member Task Force (CFMTF), consisting of clients and family members from around the State. The CFMTF has provided consultation and advice on all aspects of managed care implementation to the DMH and has been instrumental in establishing policy recommendations. The CFMTF has been an effective and accessible means of communication with policymakers in the mental health system and is now recognized widely for its broad involvement in statewide mental health initiatives.

7.2. Recommendation: All stakeholders should acknowledge that client and family member involvement is critical at both the state and local levels. All stakeholders must make a commitment to involve clients and family members at all levels of policy development by assuring funding for outreach, training, travel, and stipends.

7.3. Recommendation: The DMH and MHPs should conduct both state-level and ongoing local-level training for clients and family members in order to develop a large pool of qualified clients and family members who understand the issues and can advise and advocate effectively.

Access to culturally competent services for beneficiaries

In 1996, as part of the move to the Medi-Cal mental health managed care carve out, the DMH established a Cultural Competency Advisory Committee (CCAC) to advise on how to meet the specialty mental health needs of ethnically diverse communities. The CCAC was given the responsibility to establish cultural and linguistic standards and issue cultural competency plan requirements. In October 1997, the CCAC issued the "Addendum for Implementation Plan for Phase II Consolidation of Medi-Cal Specialty Mental Health Services—Cultural Competence Plan Requirements." The purpose of the addendum was to establish

standards and plan requirements for MHPs to achieve cultural and linguistic competency under consolidation of specialty mental health services.

By July 1998, each MHP was required to develop and submit cultural competency plans consistent with the standards and requirements, which included a population, organization, and service provider assessment. The MHPs were also required to address standards and indicators in three major areas of access, quality of care, and quality management. The intent in issuing these standards and requirements was to assist MHPs to reduce potential disparities in access and services and to improve overall quality of care for multicultural and multilingual communities. The DMH reviewed and approved the initial cultural competence plans submitted by each MHP. MHPs are required to submit annual updates of their cultural competence plan requirements to DMH.

In 1998, at the recommendation of the CCAC, the DMH established the Office of Multicultural Services to support the implementation of the cultural competence plans and to provide leadership to the DMH and local MHPs in addressing the mental health needs of California's diverse communities. Moving mental health systems to become culturally and linguistically competent is viewed as a developmental process. The CCAC established that the cultural competence plans, which were revised and reissued in May 2002, would require periodic updates. The CCAC continues to serve as an advisory body to the DMH on cultural and linguistic issues in collaboration with the work of the DMH Office of Multicultural Services.

7.4. Recommendation: The State and MHPs must integrate cultural competence into all mental health public policy and new programs.

Grievance procedures and rights of beneficiaries

MHPs must comply with the requirements of the implementation plans. Client access to appropriate, culturally competent, coordinated services is the responsibility of the MHP. Clients should also be satisfied with the services they receive. Ideally, MHPs should assist consumers and family members in navigating the mental health system, including providing assistance through the complaint and

grievance processes. A description of these processes is included in the regulations governing specialty mental health services (9, CCR, Section 1810.100 et seq.). Included in these regulations are requirements that counties provide written information to clients about grievance procedures. However, a constant concern of clients and advocates is the inconsistency with which this information is made available in each county.

7.5. Recommendation: The State Department of Mental Health should develop standards regarding grievance and appeal rights for a brochure that all MHPs would be required to use. All stakeholders need to continue to develop easily understood, consumer-friendly documents that are clear about procedures for identification and resolution of complaints and grievances, and information sources at both the state and local levels. Training and education should be provided at all levels of the mental health system so the system is user-friendly.

Adequacy of interface between health and mental health services

The interface with physical health care is a major concern of the CMHPC. How clients are referred between the systems, training of both physical health care and mental health care staff, clinical consultation, especially regarding medications, and the exchange of confidential client information must be carefully planned so that clients are assured of receiving all of the services to which they are entitled. Many adults, children, and youth served by the mental health system have serious co-occurring physical health problems. In addition, laboratory work is necessary with certain medications. Cultural and racial disparities in health outcomes should also be analyzed further. When psychiatric hospitalization occurs, medical histories must be taken and physicals performed. At times, when hospitalization for a medical problem occurs, a psychiatric consultation must be performed. All of these issues need to be clarified in terms of payment and responsibility.

7.6. Recommendation: The Chief of Multicultural Services for the DMH and the Chief, Office of Multicultural Health for the Department of Health Services should meet to coordinate efforts in addressing racial, ethnic, linguistic, and cultural disparities in physical health care.

Minimum Standards between Managed Care Plans and Mental Health Plans

The development of a written agreement that addresses the issues of interface in the delivery of Medi-Cal reimbursable services to beneficiaries who are served by a county's physical health managed care plan (MCP) and MHP is a shared responsibility between those entities. These two entities are required to execute a memorandum of understanding (MOU) that specifies the respective responsibilities of the MCP and MHP in delivering medically necessary Medi-Cal reimbursable physical health care services and specialty mental health services to beneficiaries. The DHS has issued a policy letter to the MCPs to provide a guideline for this responsibility.

7.7. Recommendation: MHPs should develop a collaborative effort with counties' MCPs to facilitate referrals between the two systems and to provide joint cross-system cultural competence training to ensure that all staff increase their knowledge and skills and improve their attitudes in providing services to ethnically and linguistically diverse populations.

7.8. Recommendation: MHPs should also develop an evaluation process to assess the effectiveness of such training.

Mental Health Training of Primary Care Physicians

A primary care physician should have enough information and training to detect, screen, and diagnose a mental illness and then to decide if he or she can appropriately treat the client or if the client should be referred to the mental health system. The medical community is addressing the need for training. In 1998, the California Medical Association adopted a resolution to collaborate with other organizations to provide mental health training for primary care physicians (California Medical Association, 1998).

7.9. Recommendation: MHPs should ensure that ongoing collaboration and communication with primary care physicians occurs.

Access to the Most Appropriate Medications

When MHPs assumed responsibility for specialty mental health services through the carve-out, the provision of pharmacy services remained

with the physical health managed care plans. MCPs expressed concerns about the expense of these new, innovative antipsychotic medications. The amount of money allocated for pharmacy services in the MCPs is fixed, which could provide a disincentive to prescribe the newer, more costly medications. Mental health advocates feared that clients would not be prescribed the newer medications because their cost would become prohibitive to the MCPs. This concern prompted the DMH to establish an agreement with the DHS that most antipsychotic medication pharmacy benefits for mental health clients would be carved out of the MCPs and billed through fee-for-service Medi-Cal.

7.10. Recommendation: The DHS and the DMH should continue to find ways to assure that the most efficacious medications to treat mental illness are prescribed to clients regardless of cost.

Risk-based Contracting

Risk-based contracting and its alternatives described previously will provide MHPs the flexibility to create or contract for services that will be most appropriate and most cost-effective for their clients. However, no actuarial data for serious mentally ill populations are available from which to establish risk-based contracting. Providers that enter into risk-based contracting should be assured that they would receive the right volume of clients to balance out the risk. These data will be critical as the DMH begins exploring the implementation of a pre-payment system in Phase III.

7.11. Recommendation: The DMH should convene a task force of mental health professionals, actuaries, insurance industry representatives, and managed care providers to determine the assumptions upon which to base the mental health managed care system design. Furthermore, those assumptions must be tested so that a basis for risk can be established to obtain more definite information on costs. This discussion should include how changing populations will change risk factors.

Oversight by the Department of Mental Health

The State has developed an oversight system that involves on-site reviews of each MHP. Review teams include county peer reviewers,

direct consumers, family members, and DMH staff. These teams identify problems and then the DMH issues plans of correction to the MHPs. The DMH then monitors the MHP as it makes these corrections. In addition, to address statewide issues of system accountability and quality improvement, the DMH has established a State Quality Improvement Council,

consisting of representatives from stakeholder organizations.

The CMHPC has the responsibility to ensure that the DMH is providing adequate oversight of the Medi-Cal managed care system. Discussion and recommendations regarding system accountability and oversight are in Chapter 8.

REFERENCES

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